45-DAY NURSING ASSESSMENT

To be completed at least every 45 days or sooner if needed.

Resident Name: _____ DOB: _____ Date Completed: _____

Next 45-day Nursing Assessment Due: _____ Date of Admission: _____

ALLERGIES – Indicate any changes.	**DIAGNOSES** – Indicate any changes.

VITAL SIGNS					
BP	*P*	*R*	*T* *°F*	*WT* *ft* *in*	*WT CHANGE: ☐ NO ☐ YES*

RESIDENT (If the resident has any wounds, a separate wound assessment form must be attached.)
GENERAL PHYSICAL FINDINGS:
HOSPITALIZATIONS/PHYSICIAN VISITS SINCE LAST REVIEW:
VITAL SIGNS OR LAB MONITORING COMPLETED AS REQUIRED: ☐ YES ☐ N/A ☐ NO (SPECIFY) RESULTS WITHIN NORMAL LIMITS: ☐ YES ☐ N/A ☐ NO (SPECIFY)
MEDICATION/TREATMENTS
CHANGES SINCE LAST REVIEW:
RESULTS OF REVIEW OF MAR, MEDICATIONS, AND ORDERS:
EFFECTIVENESS OF MEDICATIONS/TREATMENTS:

Resident: _____ **Date Completed:** _____

MEDICATION/TREATMENTS (continued)
SYMPTOMS, SIDE EFFECTS, ADVERSE REACTIONS:
APPROPRIATE STORAGE: ☐ YES ☐ NO (IF NO, EXPLAIN ISSUE IN FOLLOWING SECTION)
MEDICATION TECHNICIAN
PROBLEMS ENCOUNTERED REGARDING DOCUMENTATION, ADMINISTRATION, COMPETENCY, STORAGE, ETC.:
ACTIONS TAKEN, IF PROBLEMS ENCOUNTERED: (INDICATE THE PROBLEM, DATE OF PROBLEM, MED TECH'S NAME, INTERVENTION (REMEDIATION, VERBAL WARNING, ETC), AND FOLLOW-UP PLAN)
ENVIRONMENT
IS THE ENVIRONMENT SAFE FOR THE RESIDENT? ☐ YES ☐ NO (SPECIFY)
OVERALL
RECOMMENDATIONS AND FOLLOW-UP ACTIONS:

RN's Signature: _____ Print Name: _____